

EMPLOYEE'S REQUEST THAT COMPENSATION BE REINSTATED AFTER UNSUCCESSFUL TRIAL RETURN TO WORK (G.S. 97-32.1)

IC File # _____

Emp. Code # _____

Carrier Code # _____

Employer FEIN _____

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act

Employee's Name _____			Employer's Name _____ () _____			Telephone Number _____		
Address _____			Employer's Address _____			City _____ State _____ Zip _____		
City _____ State _____ Zip _____			Insurance Carrier _____					
() _____			() _____					
Home Telephone _____			Work Telephone _____			Carrier's Address _____ City _____ State _____ Zip _____		
Social Security Number _____			Sex _____ M _____ F _____			Date of Birth _____ / _____ / _____		
			Carrier's Telephone Number _____			Fax Number _____		

SECTION A.

EMPLOYEE: COMPLETE AND MAIL TO EMPLOYER AND CARRIER/ADMINISTRATOR, AND TO THE INDUSTRIAL COMMISSION AT THE ADDRESS BELOW:

- I request that my total disability compensation be resumed immediately. I had a trial return to work with _____ (name of employer) from _____ (date first worked) until _____ (date last worked).
The date of my injury by accident or the date of disability from my occupational disease was _____
- Explain in detail the reasons you are no longer working: _____
- The employee **MUST** obtain the following from an authorized treating physician:

TREATING PHYSICIAN'S STATEMENT			
This is to certify that the employee is unable to continue the trial return to work due to the employee's injury for which compensation has been paid. My medical specialty is: _____			
SIGNATURE OF AUTHORIZED TREATING PHYSICIAN _____		PRINTED NAME _____ DATE _____	
ADDRESS _____		CITY _____ STATE _____ ZIP _____	

IF RETURN TO WORK WAS WITH THE EMPLOYER FROM WHOM YOU HAVE RECEIVED WORKERS' COMPENSATION, SIGN HERE AND DO NOT COMPLETE THE REMAINDER OF THIS FORM. IF RETURN TO WORK WAS WITH A DIFFERENT EMPLOYER, COMPLETE SECTION B BELOW.

SIGNATURE OF EMPLOYEE _____ DATE _____

SECTION B.**EMPLOYEE'S RELEASE OF EMPLOYMENT INFORMATION**

I hereby request and authorize my last employer, _____ (Name and address of last employer)

to release to my prior employer and carrier/administrator listed above, or their attorney of record, the following information relating to my trial return to work: first and last date worked, total wages earned, and the reasons this employee is no longer so employed.

**READ BEFORE
SIGNING**

SIGNATURE OF EMPLOYEE _____ DATE _____

SEND A COPY OF THIS FORM TO THE EMPLOYER AND CARRIER/ADMINISTRATOR FROM WHOM YOU WERE RECEIVING WORKERS' COMPENSATION.
SEND THE ORIGINAL TO THE INDUSTRIAL COMMISSION AT THE ADDRESS BELOW.